Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012129	A. BUILDING _____ B. WING _____	C 03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIR ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00104019. Complaint IN00104019 unsubstantiated, due to lack of evidence Survey dates: March 11, 12, 2012 Facility number: 012129 Provider number: 012129 AIM number: N/A Surveyor: Jeri Curtis, RN Census bed type: Residential: 42 Total: 42 Census payor type: Other: 42 Total: 42 Sample: 3 Crown Pointe of Anderson was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00104019. Quality review completed 3/12/12 Cathy Emswiller RN	R 000		